Society of Professional Benefit Administrators

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1717-P

September 27, 2019

Dear Ladies and Gentlemen:

These comments on CMS-1717-P are submitted on behalf of the Society of Professional Benefit Administrators ("SPBA").

SPBA is the leading national trade association of Third Party Administration (TPA) firms hired by employers and employee benefit plans to provide contract-based management of their employee benefit plans. It is estimated that 55% of US workers and their dependents in non-federal health coverage are in plans administered by an SPBA member TPA. SPBA member TPA firms operate much like independent CPA or law firms, providing professional claims and benefit plan administration for a multitude of client employers and benefit plans.

A unique perspective of SPBA is that clients of TPA firms include every size and form of employment, including large and small employers, non-federal governmental plans, union, non-union, collectively bargained multiemployer plans (Taft-Hartley), as well as plans representing religious entities. The majority of these clients are ERISA self-funded plans and sponsors; some of our TPA members also provide services to other types of plans, including fully-insured plans and HMOs.

SPBA works closely with the relevant federal agencies to understand the constant flow of regulations and interpretations. This knowledge is used to give perspective and education to plan sponsors, including trustees. The agencies have appreciated our insights and have shared with us that this interaction helps the agencies in understanding issues and developing implementing regulations.

SPBA has been dialoging with HHS on the issue of price transparency for many years now and we submitted a policy brief in the Fall of 2011 on Section 2718(e) of the Public Health Service Act, Standard Hospital Charges, and then submitted an updated policy brief in the Spring of 2012 and another brief in the summer of 2014. In June 2018, we submitted further comments on transparency.

We are encouraged by the recent proposal on hospital price transparency from CMS and commend CMS and HHS for the ideas and approach set forth. We believe that the current lack of transparency is not

serving the public effectively and changes are needed. We welcome this opportunity to share our perspective.

The Current State of Transparency and the Healthcare Market
SPBA's longstanding efforts to improve price transparency in the healthcare market reflect our members' strong interest in these issues.

Employers and plan sponsors need more transparency in the market so they can reward high value providers and the plan participants that choose them. Employers and plan sponsors play a critical role in helping consumers make sense of price information. More than 175 million Americans receive health coverage through employer-sponsored plans. When crafting transparency requirements, we urge HHS to be mindful that employers and plan sponsors have the ability to use more complex transparency information and assist plan participants in understanding their choices.

Price transparency must include the total cost of healthcare, and not narrowly focus on patient cost-sharing or out-of-pocket costs. This information is only the tip of the pricing iceberg, and is not useful in measuring value. Such a narrow focus will do little to bring down the overall cost of care. However, real transparency that encompasses the total cost of care has the power to bring down costs for the whole system – patients, plans, and the government – while preserving quality of care.

Proposed Definition of "Hospitals"
In the proposed rule, CMS proposes defining a hospital as an "institution in any State in which State or applicable local law provides for the licensing of hospitals, (1) is licensed as a hospital pursuant to such law or (2) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing."

We applaud the goal of capturing all hospitals operating in the United States, including those that might not be considered hospitals for the purpose of Medicare participation. Absolutely all facilities operating as hospitals should be required to maintain compliance with transparency rules.

SPBA would suggest going further to encompass out-patient facilities and clinics that operate in the healthcare market. In some cases, these facilities provide similar services or procedures and may compete with hospitals. For example, an MRI may be conducted at a hospital or a stand-alone clinic. The real price difference is meaningful and valuable for consumers and plans to know.

Definition of "Standard Charges"
In the commercial market, hospital charges have little meaning to the consumer in the health care transaction. The hospital charge does not reflect what the hospital generally accepts as payment in full, often with the hospital charging different amounts to different payers for the same procedure. Commercial contracted discounts with providers can range anywhere from 5% to 75% off billed charges (depending on the provider, service and geographical region), rendering the charge virtually meaningless. If the hospital "standard charge" for a procedure is $1,000, the hospital is often accepting payment anywhere from $950 to $250. The consumer has no way of knowing what the hospital will accept as payment in full and in most cases lacks the sophistication to know that discounts are available. The consumer is unaware of the complicated discount arrangements that hospitals offer to certain purchasers and not to others.

The current system hurts the most vulnerable health care consumer the most: the uninsured. Those without coverage lack the support system to navigate a system that is shrouded in secret, preferred treatment arrangements for certain consumers and not others. Those with coverage are also prevented from shopping effectively based on price and quality.

Offering the consumer the billed charge does little to educate the public of the true price of care and can even do harm in the effort to encourage consumers to use price information as a basis for economic decision- making. The chargemaster is not an accurate measure of a hospital's "standard charges" since it does not reflect the true price the hospital is willing to accept for payment.

The prices a hospital will accept depend upon many factors. For example, the prices change based upon whether the consumer is insured or not, who the insurance payer is or if the consumer is paying in cash. The price differs depending upon who is making the payment, which results in price discrimination against the consumer. This creates further unfair cost shifting against consumers. A higher price should not be charged based on the fact that certain consumers will pay all of the billed amount. Regardless of whether they have coverage or not, consumers and their representatives deserve to have a platform for uniform and consistent comparative evaluation of an episode of care at a facility. Without transparency of the full and total pricing picture, this cannot be accomplished.

In the proposed rule, CMS requests information on various alternative approaches to standard charges. One of those proposals is a volume-driven negotiated charge. SPBA recommends against this approach. Accepting a 'volume-driven' approach perpetuates the idea that insurers have been able to drive prices lower based on volume-driven negotiations. However, that very approach has been a barrier to transparency and true market competition. SPBA would also argue it has not been effective in containing healthcare costs, let alone lowering costs or establishing standard pricing.

Instead, SPBA suggests a standard provider pricing disclosure chart that provides meaningful price information across the spectrum of patients and payers, including useful metrics like mean, median, maximum, and minimum billed *and accepted* amounts.

Payer-Specific Negotiated Rates

One of the specific disclosures discussed in the CMS proposal is payer-specific negotiated rates. SPBA praises CMS for its forward-thinking vision on proposing this level of disclosure and transparency. This information would be very valuable for both consumers and plans, and would open up the market for true competition.

If HHS declines to pursue this approach, we offer an alternative. SPBA suggests a disclosure chart developed by SPBA members and discussed below, which provides meaningful information that plans and employers could use to identify and reward high value providers without payer-specific negotiated rates being made publicly available.

SPBA Suggested Disclosure Chart

In past comments and briefs, SPBA has suggested a provider pricing disclosure chart. SPBA offers this chart, refined and improved, again for consideration as CMS weighs various options for pursuing price transparency.

This disclosure chart is essentially an accounting report, containing information hospitals and facilities should already have. Providers would also have three months to compile the necessary data each quarter. As you see in the below sample, the report to be filed 6/30/2020 will cover the rolling 12-month reporting period from 4/1/2019-3/31/2020.

Provider Transparency Information Disclosure Chart

Hospitals - Inpatient - MSDRGs and
Outpatient - Primary HCPCS

12-month Reporting Period: 4/1/19-3/31/20 **Report Date: 6/30/20**

MSDRG/Primary HCPCS XXXXXXXXX	**Medicare Patients**	**Medicaid Patients**	**Commercial Contracted/In-Network Patients**	**Commercial Non-Contracted/Non-Network Patients**
Number of Procedures in period				
Number of Bed Days				
Total Billed Charges in period	$	$	$	$
Total Amount Received/Paid for services in period (all sources of payment)	$	$	$	$
Mean Billed Charge Amount	$	$	$	$
Mean Accepted Amount	$	$	$	$
Median Billed Charge Amount	$	$	$	$
Median Accepted Amount	$	$	$	$
Minimum Billed Charge Amount	$	$	$	$
Maximum Billed Charge Amount	$	$	$	$
Minimum Accepted Amount	$	$	$	$
Maximum Accepted Amount	$	$	$	$

--Provide quarterly updates - at end of each quarter, provide for rolling 12-month period ending with the end of the immediately prior quarter so payments largely completed

--Submit to CMS in the attached file spec
--CMS makes available via online searchable website as well as national full files for member and plan sponsor advocacy.

Glossary:
--Accepted Amount: The allowed amount accepted by the provider for payment in full for this service. This is the total payment result of the contracted rates for a commercial contracted payor or the patient negotiated or final accepted amount for non-contracted commercial consumers.
--Commercial In-Network/Contracted: Commercial patients enrolled in a plan that has an established contract with the provider. All sources of payment (payor and patient) should be included in these values.
--Commercial Non-Contracted/Non-Network: Commercial patients enrolled in a plan that does not have an established contract with the provider. All sources of payment (payor and patient) should be included in these values.
--Medicare Patients: patients enrolled in Medicare parts A & B. All sources of payment (payor and patient) should be included in these values.
--Medicaid Patients: patients enrolled in Medicaid. All sources of payment (payor and patient) should be included in these values.

Since Medicare represents a significant percentage of health care spending in the United States, it is considered the standard measuring stick by which other prices or charges are compared. Specifically, in Section 2718(e), the law says the charges must include those for diagnosis-related groups as established through the Social Security Act, which is expressed through Medicare. Therefore, reference to the Medicare standards in the listing of any "charge" is important since it is the only price that has consistency, consumer awareness, and structure.

Access to the full pricing spectrum would complete the initial picture of information a consumer or consumer representative would need to fairly assess the value of the prospective services. Therefore, for the public to better understand the term "charges" and to address the dilemma of relevant and inconsistent pricing in the hospital and facilities markets, pricing disclosures should include basic, but meaningful, amounts for the public to make their own determination of relevance. In order to reflect both inpatient and outpatient services, these amounts should include the following components for each MS-DRG and APC (ambulatory payment classification) as it relates to Medicare patients, Medicaid patients, Commercial Contracted/In-Network Patients, and Commercial Non-Contracted/Non-Network Patients:

1. Number of procedures performed by the provider in the reported period
2. Number of bed days
3. Total Billed Charges in the reporting period
4. Total Amount Received/Paid for services in the reporting period
5. Mean Billed Charged Amount
6. Mean Accepted Amount
7. Median Billed Charged Amount
8. Median Accepted Payment
9. Minimum Billed Charged Amount
10. Maximum Billed Charged Amount

11. Minimum Accepted Payment
12. Maximum Accepted Payment

File Format Requirements

SPBA further suggests CMS take a prescriptive approach on how data should be formatted. In order for pricing disclosures to have the most meaningful impact, data must be presented in a consistent and standardized manner. SPBA suggests CMS publish very specific data requirements that all providers would be required to adhere to. There should be a normalized data structure.

To illustrate this, SPBA developed the following file specifications to accompany our suggested Provider Information Disclosure Chart.

Field	FieldType	Notes
FacilityMedicareID	Number	CMSID for the reporting facility
PayorType	*String*	Medicare, Medicaid, Commercial Contracted/In-Network, Commercial Non-Contracted/Non-Network,
PayorNumber	*Number*	*Payor identification number if specific regulation; if not payer specific, this field would be omitted and data would be aggregated instead by payer type only.*
Code	Number	MSDRG Code for Inpatient Admissions or the primary HCPCS code for outpatient procedures
CodeType	String	MSDRG for Inpatient or HCPCS for Outpatient
AdmissionType	String	Inpatient or Outpatient
MeanCharge	Currency/Double	The average of gross billed charges for this code, payer type, (payer), and time period
MedianCharge	Currency/Double	The Median gross billed charge for this code, payor type, (Payor), and time period
MinCharges	Currency/Double	The minimum gross billed charge for this code for the time period
MaxCharges	Currency/Double	The Maximum gross billed charge for this code for the time period
MeanAcceptedAmount	Currency/Double	The average accepted amount for this code, payor type, (payor), and time period
MedianAcceptedAmount	Currency/Double	The average accepted amount for this code, payor type, (payor), and time period
Discharges	Number	Number of discharges for this code, payor type, (payor), and time period
BedDays	Number	Number of bed days for this code, payor type, (payor) and time period

Conclusion
SPBA applauds CMS for their efforts to address much-needed price transparency. Ultimately, the price disclosure chart SPBA suggests provides a simple, effective, and efficient approach to ensuring the most useful information is available to consumers and plans in a standard, readable format. With this information, consumers could compare prices and make informed health care purchasing decisions for themselves and their families.

We welcome the opportunity to discuss these ideas further with you in person or on a conference call. We look forward to hearing from you.

Respectfully Submitted,

Anne C. Lennan
President
SPBA